

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
13543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 13543 51										
1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill x 2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Brown</u> Middle <u>Brown</u> Last					4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>19-57</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>cel</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>about 5</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheepher in forage</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>?</u>					14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pearl Brown (wife)</u> Address <u>Centerville md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion (Sudden)</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>W. Henry Fisher</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, or REMOVAL (Specify)			22b. DATE THEREOF <u>12-7</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Truants Neck</u>		22d. LOCATION (City, town, or county) (State) <u>near Chestertown Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Rane</u>					ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>12/5</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar D. Rane</u>	

MISSOURI - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, file 13550 12/23/57 for

CERTIFICATE OF DEATH

Reg. Dist. No. 135482

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>x2 Centerville</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>CONNOLLY</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22-1872</u>	9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Rep. Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael Thomas Connolly</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Shortall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>m</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-28-3254</u>			
17. INFORMANT <u>M. Munnis E Connolly</u>				Address <u>Centerville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 1-1957</u> to <u>Dec 5-1957</u> that I last saw the deceased alive on <u>Dec 5-1957</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				ADDRESS (Street, city or town, state) <u>Centerville Md</u>			
DATE SIGNED <u>12/7-57</u>							
PHYSICIAN'S NAME (Type) <u>W. HENRY FISHER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestfield</u>		22d. LOCATION (City, town, or county) <u>Centerville Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward B. Burt</u> ADDRESS <u>Baltimore Centerville Md</u>				24a. REC'D BY REGISTRAR <u>12-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elvie Armstrong</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

135454

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Grasonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isabelle Middle A. Last Dadds		4. DATE OF DEATH Month December Day 19 Year 19 57	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William DeLacy		14. MOTHER'S MAIDEN NAME Annette Hass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nettie Aaron-Stevensville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE W. Henry Fisher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. HENRY FISHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/29-57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec. 22	22c. NAME OF CEMETERY OR CREMATORY Centreville
22d. LOCATION (City, town, or county)		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Kane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE W. Henry Aldridge	

BUREAU V. G.

DEC 26 1957

RECEIVED

FOR STATE
HEALTH DEPT.

13552

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Harry</u> Last <u>Drummond</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>19</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1935</u> 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foodpacking</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY DRUMMOND</u>		14. MOTHER'S MAIDEN NAME <u>Edith PAIGE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>VIRGIE JOHNSON-AUNT</u> Address <u>Grasonville Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Fractured</u> 816 X DUE TO (b) <u>skull - broken neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Car containing passengers ran into rear of truck</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State highway</u>		20f. (City or town) (County) (State) <u>Narrows Q.A.Co. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/19-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/22/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>EASTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Stelton</u>		24. REC'D BY REGISTRAR <u>12/22/57</u>	
ADDRESS <u>317 High St. Cambridge Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Newnes</u>	

STATE OF
NEW YORK

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1957

RECEIVED

13553

CERTIFICATE OF DEATH

1355154
224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 mi. x 2 Rural - Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Sylvia</u> Middle <u>Eugenia</u> Last <u>Flamer</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3, 1957</u>		9. AGE (In years last birthday) yrs. <u>2</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Ike Foreman</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Flamer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother</u> Address <u>Queenstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 3, 1957</u> to <u>Dec. 8, 1957</u> that I last saw the deceased alive on <u>Dec. 7, 1957</u> , and that death occurred at <u>493X</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederic M. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown Md.</u> DATE SIGNED <u>12/8/57</u>			
PHYSICIAN'S NAME (Type) <u>Frederic M. Hoyt M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty, Canton, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>12/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Aldridge</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John F. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. OCCUPATION <i>Engineer</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
11. SIGNATURE OF REGISTRAR <i>John F. Smith</i>		12. SIGNATURE OF WITNESSES <i>John F. Smith</i>	
13. SIGNATURE OF DECEASED <i>John F. Smith</i>		14. SIGNATURE OF DECEASED <i>John F. Smith</i>	
15. SIGNATURE OF DECEASED <i>John F. Smith</i>		16. SIGNATURE OF DECEASED <i>John F. Smith</i>	
17. SIGNATURE OF DECEASED <i>John F. Smith</i>		18. SIGNATURE OF DECEASED <i>John F. Smith</i>	
19. SIGNATURE OF DECEASED <i>John F. Smith</i>		20. SIGNATURE OF DECEASED <i>John F. Smith</i>	
21. SIGNATURE OF DECEASED <i>John F. Smith</i>		22. SIGNATURE OF DECEASED <i>John F. Smith</i>	
23. SIGNATURE OF DECEASED <i>John F. Smith</i>		24. SIGNATURE OF DECEASED <i>John F. Smith</i>	
25. SIGNATURE OF DECEASED <i>John F. Smith</i>		26. SIGNATURE OF DECEASED <i>John F. Smith</i>	
27. SIGNATURE OF DECEASED <i>John F. Smith</i>		28. SIGNATURE OF DECEASED <i>John F. Smith</i>	
29. SIGNATURE OF DECEASED <i>John F. Smith</i>		30. SIGNATURE OF DECEASED <i>John F. Smith</i>	
31. SIGNATURE OF DECEASED <i>John F. Smith</i>		32. SIGNATURE OF DECEASED <i>John F. Smith</i>	
33. SIGNATURE OF DECEASED <i>John F. Smith</i>		34. SIGNATURE OF DECEASED <i>John F. Smith</i>	
35. SIGNATURE OF DECEASED <i>John F. Smith</i>		36. SIGNATURE OF DECEASED <i>John F. Smith</i>	
37. SIGNATURE OF DECEASED <i>John F. Smith</i>		38. SIGNATURE OF DECEASED <i>John F. Smith</i>	
39. SIGNATURE OF DECEASED <i>John F. Smith</i>		40. SIGNATURE OF DECEASED <i>John F. Smith</i>	
41. SIGNATURE OF DECEASED <i>John F. Smith</i>		42. SIGNATURE OF DECEASED <i>John F. Smith</i>	
43. SIGNATURE OF DECEASED <i>John F. Smith</i>		44. SIGNATURE OF DECEASED <i>John F. Smith</i>	
45. SIGNATURE OF DECEASED <i>John F. Smith</i>		46. SIGNATURE OF DECEASED <i>John F. Smith</i>	
47. SIGNATURE OF DECEASED <i>John F. Smith</i>		48. SIGNATURE OF DECEASED <i>John F. Smith</i>	
49. SIGNATURE OF DECEASED <i>John F. Smith</i>		50. SIGNATURE OF DECEASED <i>John F. Smith</i>	
51. SIGNATURE OF DECEASED <i>John F. Smith</i>		52. SIGNATURE OF DECEASED <i>John F. Smith</i>	
53. SIGNATURE OF DECEASED <i>John F. Smith</i>		54. SIGNATURE OF DECEASED <i>John F. Smith</i>	
55. SIGNATURE OF DECEASED <i>John F. Smith</i>		56. SIGNATURE OF DECEASED <i>John F. Smith</i>	
57. SIGNATURE OF DECEASED <i>John F. Smith</i>		58. SIGNATURE OF DECEASED <i>John F. Smith</i>	
59. SIGNATURE OF DECEASED <i>John F. Smith</i>		60. SIGNATURE OF DECEASED <i>John F. Smith</i>	
61. SIGNATURE OF DECEASED <i>John F. Smith</i>		62. SIGNATURE OF DECEASED <i>John F. Smith</i>	
63. SIGNATURE OF DECEASED <i>John F. Smith</i>		64. SIGNATURE OF DECEASED <i>John F. Smith</i>	
65. SIGNATURE OF DECEASED <i>John F. Smith</i>		66. SIGNATURE OF DECEASED <i>John F. Smith</i>	
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69. SIGNATURE OF DECEASED <i>John F. Smith</i>		70. SIGNATURE OF DECEASED <i>John F. Smith</i>	
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73. SIGNATURE OF DECEASED <i>John F. Smith</i>		74. SIGNATURE OF DECEASED <i>John F. Smith</i>	
75. SIGNATURE OF DECEASED <i>John F. Smith</i>		76. SIGNATURE OF DECEASED <i>John F. Smith</i>	
77. SIGNATURE OF DECEASED <i>John F. Smith</i>		78. SIGNATURE OF DECEASED <i>John F. Smith</i>	
79. SIGNATURE OF DECEASED <i>John F. Smith</i>		80. SIGNATURE OF DECEASED <i>John F. Smith</i>	
81. SIGNATURE OF DECEASED <i>John F. Smith</i>		82. SIGNATURE OF DECEASED <i>John F. Smith</i>	
83. SIGNATURE OF DECEASED <i>John F. Smith</i>		84. SIGNATURE OF DECEASED <i>John F. Smith</i>	
85. SIGNATURE OF DECEASED <i>John F. Smith</i>		86. SIGNATURE OF DECEASED <i>John F. Smith</i>	
87. SIGNATURE OF DECEASED <i>John F. Smith</i>		88. SIGNATURE OF DECEASED <i>John F. Smith</i>	
89. SIGNATURE OF DECEASED <i>John F. Smith</i>		90. SIGNATURE OF DECEASED <i>John F. Smith</i>	
91. SIGNATURE OF DECEASED <i>John F. Smith</i>		92. SIGNATURE OF DECEASED <i>John F. Smith</i>	
93. SIGNATURE OF DECEASED <i>John F. Smith</i>		94. SIGNATURE OF DECEASED <i>John F. Smith</i>	
95. SIGNATURE OF DECEASED <i>John F. Smith</i>		96. SIGNATURE OF DECEASED <i>John F. Smith</i>	
97. SIGNATURE OF DECEASED <i>John F. Smith</i>		98. SIGNATURE OF DECEASED <i>John F. Smith</i>	
99. SIGNATURE OF DECEASED <i>John F. Smith</i>		100. SIGNATURE OF DECEASED <i>John F. Smith</i>	

BUREAU V. 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13552

13554

CERTIFICATE OF DEATH

Reg. Dist. No.

253

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Love Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Love Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Elizabeth</u> Last <u>Foley</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Wm. Benjamin Shawn</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ann Legg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. John Shawn</u>		Address <u>Love Point, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - Arteriosclerosis</u> DUE TO (c) <u>Cardio-Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>See. Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>55</u> , to <u>Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queens town, Md.</u> DATE SIGNED <u>12/27/57</u> ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 30</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Ely H. Hester</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. RACE</p>		<p>5. BIRTH DATE</p>		<p>6. BIRTH PLACE</p>		<p>7. BIRTH DATE</p>		<p>8. BIRTH PLACE</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. CAUSE OF DEATH</p>		<p>13. MANNER OF DEATH</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF REGISTRAR</p>		<p>16. SIGNATURE OF WITNESS</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF NEXT OF KIN</p>		<p>19. SIGNATURE OF SURVIVOR</p>		<p>20. SIGNATURE OF SURVIVOR</p>		<p>21. SIGNATURE OF SURVIVOR</p>		<p>22. SIGNATURE OF SURVIVOR</p>		<p>23. SIGNATURE OF SURVIVOR</p>		<p>24. SIGNATURE OF SURVIVOR</p>	
<p>25. SIGNATURE OF SURVIVOR</p>		<p>26. SIGNATURE OF SURVIVOR</p>		<p>27. SIGNATURE OF SURVIVOR</p>		<p>28. SIGNATURE OF SURVIVOR</p>		<p>29. SIGNATURE OF SURVIVOR</p>		<p>30. SIGNATURE OF SURVIVOR</p>		<p>31. SIGNATURE OF SURVIVOR</p>		<p>32. SIGNATURE OF SURVIVOR</p>	

BUREAU V. S.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7,8,9 Film 224 1-15-58 et

Reg. Dist. No. 290

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Marie</u> Last <u>Hazelton</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not given</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Hazelton</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mary Hazelton (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Broken neck</u> 816X DUE TO (b) <u>fractured skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto in which she was riding ran into a truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Highway</u>	20f. (City or town) <u>Grasonville</u> (County) <u>QA</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>12/21/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Md</u>		22d. LOCATION (City, town, or county) <u>Chester Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Ashwell</u>		24a. REC'D BY REGISTRAR <u>DATE 1/4/58</u>	
ADDRESS <u>Toson Md</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newen</u>	

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BUREAU V. 2

13556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>EUGENE</u> Middle <u>PENNINGTON</u> Last		4. DATE OF DEATH Month <u>DEC.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HOUSTON PENNINGTON</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN HARDESTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-1349</u>	
17. INFORMANT Address <u>MD. BARCLAY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardio Vascular weakness</u> DUE TO (c) <u>Arteriosclerotic diathesis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>23 mos</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>48</u> , to <u>Dec 7</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>Millington MD</u> DATE SIGNED <u>12/9/57</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		<u>Millington MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>12/10/57</u>	<u>SUDLERSVILLE CEM.</u>	<u>SUDLERSVILLE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>Edgar L. Lacey</u> DATE <u>11 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18550

Page 1 of 1

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
MARITAL STATUS [Faint text, possibly "Married"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "11/10/1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF BURIAL SOCIETY [Faint signature]		SIGNATURE OF FUNERAL HOME [Faint signature]		SIGNATURE OF MINISTER [Faint signature]	

BUREAU V. S.

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY OBTAINED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

13557

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Queen Anne</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIRGIE</u> First <u>ETTA</u> Middle <u>RICE</u> Last		4. DATE OF DEATH Month <u>DEC</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 23, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIDNEY PINDER, SR.</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE JESTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>HARVEY RICE, Queen Anne Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>3 days</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis - Paralysis of the bladder - Osteoporosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Dec 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 1st</u> , 19 <u>57</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kurt Lederer</u> M.D.		ADDRESS (Street, city or town, state) <u>Queen Anne</u> DATE SIGNED <u>12/4/57</u>	
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 4, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Hillbrow Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Morrison</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR <u>DATE 6 1958</u>	24b. REGISTRAR'S SIGNATURE <u>A. H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. S.

JAN 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13556

CERTIFICATE OF DEATH

Reg. Dist. No.

251

13558

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>		c. LENGTH OF STAY IN 1b <u>Xo Rural Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Walls</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hewitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Earl Smith--Chestertown, Md. R.R. #1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arricular fibrillation</u> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Insanction</u> DUE TO (c) <u>Sanility</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>name</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19</u> , 19 <u>57</u> , to <u>Dec 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 9/57</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>Millington Md.</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		DATE SIGNED <u>10/12</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 13</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>		22d. LOCATION (City, town, or county) (State) <u>Sudlersville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>10/12</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar H. Kane</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1892		NEW YORK	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
FARMER		HEART DISEASE		NATURAL		2 WEEKS		HOME	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
DEC 10 1957		10:00 AM		100.0		80		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
DEC 10 1957		DEC 10 1957		DEC 10 1957		DEC 10 1957		DEC 10 1957	

BUREAU V. 2

DEC 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1355751

1. PLACE OF DEATH a. COUNTY <i>W. Chester</i> b. CITY OR TOWN <i>W. Chester</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Chester</i>		c. LENGTH OF STAY IN 1b <i>1 Day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Tobtown Smithville Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Snyder</i> Last <i>Snyder</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 1905</i>
9. AGE (In years last birthday) <i>52</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>2</i> Hours <i>0</i> Min. <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>MT Horry, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>J. Snyder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>420.1</i>	
17. INFORMANT <i>Geo. M. Snyder</i>		Address <i>W. Chester</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Deer hunting</i> (c) <i>Deer</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W. F. McPherson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. F. McPherson</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 4/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cooperstown Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Beverly, Baltimore Co. MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Williams</i>		24a. REC'D BY REGISTRAR <i>12/2</i>	
ADDRESS <i>Chesapeake Md</i>		24b. REGISTRAR'S SIGNATURE <i>Edgar D. Lane</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. 3

DEC 9 1957

RECEIVED

13560 CERTIFICATE OF DEATH

Reg. Dist. No.

300

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON X2 RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE F. VOGEL</u>				4. DATE OF DEATH Month Day Year <u>DEC. 29, 1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FIREMAN FIRE CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PHILA. PA.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HARRY VOGEL</u>				14. MOTHER'S MAIDEN NAME <u>REGINA HORNICKLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. GEORGE VOGEL MILLINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation of the heart.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degeneration of the myocardium.</u> DUE TO (c) <u>Anterior coronary</u>							INTERVAL BETWEEN ONSET AND DEATH <u>42 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6.17</u> , 19 <u>57</u> , to <u>12.29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12.27</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>GEORGE KORALEWSKI</u> M.D.				ADDRESS (Street, city or town, state) <u>MILLINGTON, MD.</u> DATE SIGNED <u>12.30.57</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE KORALEWSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MILLINGTON, PENN. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u> ADDRESS <u>Millington, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Ed. Fellows</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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